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	155743	A. BUILDING _____ B. WING _____	03/18/2011

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F0000	This visit was for a Recertification and State licensure survey. This visit included the investigation of complaint number IN00086360. Complaint number IN00086360 substantiated. No deficiencies related to the allegations are cited. Survey dates: March 14, 15, 16, 17, and 18, 2011. Facility number: 000288 Provider number: 155743 Aim number: 100287380 Survey team: Brenda Nunan, RN TC Megan Wyant, RN Cheryl Groth, RN Census bed type: SNF/NF: 54 Total: 54 Census payor type: Medicare: 8 Medicaid: 35 Other: 11	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Total: 54 Sample: 14 Supplemental sample: 6 These deficiencies also reflect State findings in accordance with 410 IAC 16.2. Quality review completed 3-23-11 Cathy Emswiller RN			
F0164 SS=D	Based on observation, record review, and interview, the facility failed to ensure privacy was provided during blood glucose monitoring and medication administration. This deficient practice effected 2 residents reviewed for privacy in a supplemental sample of 5. (Residents #30 and #34; LPN #1 and LPN #2) Findings include: 1a. During a medication administration observation with	F0164	1. Resident #30 and #34 were interviewed by the Social Services Director and no adverse effects were noted. 2. All Residents were assessed and no other Residents were found to be affected.3. The staff were re-educated on the facility policies and procedures for providing privacy during care. The Director of Nursing or designee will make observation rounds 5x weekly. The findings will be documented and the rounds will completed indefinitely.4. The Director of Nursing or designee will report the findings of these audits to Quality Assurance monthly x 3 months and then at least quarterly.	04/08/2011

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	LPN #1 on 3/15/11 at 11:00 a.m., the following was observed: LPN #1 entered resident # 30's room to administer the resident's 12:00 p.m., medications and check the resident's blood glucose level. The resident was sitting on the window side of the room in a recliner. The LPN administered one Artificial tears eye drop to both eyes. She then handed the resident a bottle of Deep Sea nasal spray for the resident to administer to himself. The LPN then went to the medication cart just outside the resident's doorway and prepared the blood glucose machine to check the resident's blood glucose level. The LPN took Resident #30's blood glucose level. The LPN went back to the medication cart just outside the doorway and prepared the resident's sliding scale and scheduled insulin. The LPN administered the insulin in the resident's upper right arm. At no time during the observation did the			

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	LPN attempt to provide privacy to the resident by pulling the privacy curtain or closing the door. The resident's roommate was in the room in bed. There were staff and resident's in the hallway passing by the room during the observation. During an interview with the LPN immediately following the observation she indicated she would "normally pull the curtain or close the door when giving medications." She further indicated "I should have done that and I didn't." 1b. During a medication administration observation with LPN # 2 on 3/15/11 at 4:33 p.m., the following was observed: LPN #2 entered resident #30's room and checked the resident's blood glucose level. The resident was sitting in a recliner in the room on the window side of the room. The LPN stood at the medication cart			

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	outside the resident's room and prepared the blood glucose machine to check the resident's blood glucose level. The LPN took Resident # 30's blood glucose level. At no time during the observation did the LPN attempt to provide privacy to the resident by pulling the privacy curtain or closing the door. The resident's roommate was in the room watching the resident receive the blood glucose monitoring. There were staff and resident's in the hallway during the observation. 2. During a medication administration observation with LPN # 2 on 3/15/11 at 4:20 p.m., the following was observed: LPN # 2 entered Resident #34's room to administer two eyedrops and oral medications. The LPN administered one Natural Balance Tears eyedrop in both eyes. The LPN then administered a blood pressure medication provided in a			

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	spoon of applesauce. The LPN waited 5 minutes, and then administered one Combigan eye drop in both eyes. At no time did the LPN attempt to provide privacy to the resident by closing the resident's door. During an interview with LPN #2 on 3/15/11 at 4:44 p.m., the LPN indicated "privacy should be provided for all treatments and I didn't do that. I should have." During an interview with the Administrator on 3/15/11 at 4:45 p.m., he indicated "privacy should be provided for all treatments." A policy and procedure titled "Blood Glucose Monitoring Procedure" dated 9/05, revised 1/10/10, and 3/11, provided by Corporate Consultant #1 on 3/18/11 at 10:00 a.m., identified as current, indicated "...Assemble equipment and take to bedside. Explain procedure and provide			

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	privacy...." A policy and procedure titled "Administering insulin" dated 9/05, identified as current, provided by the Administrator on 3/15/11 at 6:40 p.m., indicated "...Bring equipment to bedside and provide privacy for resident...." A policy and procedure titled "Eye Drop Instillation Procedure" dated 9/05, identified as current, provided by the Administrator on 3/15/11 at 6:40 p.m., indicated "...Explain procedure to resident and bring equipment to bedside. Screen resident...." During an interview with the Administrator on 3/17/11 at 4:00 p.m., he indicated he interprets the statement in the Eye Drop policy "screen resident" to mean the staff should pull the privacy curtain prior to administering medications. 3.1-3(o)			

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F0241 SS=E	Based on observation and interview, the facility staff failed to ensure resident dignity was maintained related to the use of clothing protectors to wipe residents mouths during meals. This deficient practice effected 2 of 14 residents in a sample of 14; 3 residents in a supplemental sample of 5 reviewed for dignity. (Residents #1, #42, #4, and #27; RN # 1, CNA # 2, CNA #3, CNA #4, and CNA #5) Findings include: 1. During the lunch meal observation on 3/14/11 from 11:45 a.m., through 12:25 p.m., the following was observed:	F0241	THE FACILITY WISHES TO IDR THIS TAG1. The Residents cited in the survey were interviewed by the Social Services Director and no adverse effects were noted.2. All Residents were assessed and no other Residents were found to be affected.3. Staff were re-educated on Resident hygiene during meals. The Director of Nursing or designee will monitor 5 meals weekly. This observation will include all three meals and will continue indefinately.4. The Director of Nursing or desigee will report the findings of these audits to Quality Assurance monthly x 3 months and then at least quarterly.	04/08/2011

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	CNA #3 was feeding Resident #4. The CNA used the clothing protector 11 times during the meal to wipe the resident's mouth. There was a napkin on the resident's meal tray. CNA #4 was feeding Resident #42. The CNA used the clothing protector 11 times during the meal to wipe the resident's mouth. There was a napkin on the resident's meal tray. CNA #5 was feeding Resident #27. The CNA used the clothing protector 4 times during the meal to wipe the resident's mouth. There was a napkin on the resident's meal tray. 2. During the evening meal on 3/16/11 at 5:25 P.M., the following was observed: CNA # 2 used a clothing protector to wipe Resident # 42's mouth two times.			

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F0241 SS=E	3. During observations in the main dining room at 6:20 p.m., RN # 1 was observed using a clothing protector to wipe Resident # 1's mouth with a clothing protector instead of a napkin. During an interview with the Administrator, Director of Nursing, Assistant Director of Nursing, and the Corporate Quality Assurance Nurse on 3/15/11 at 6:40 p.m., the Administrator indicated the staff have historically used clothing protectors in the past to wipe residents mouths. He indicated the staff should have used napkins or a wash cloth to wipe the residents mouths. He indicated he understood the concern.	F0241	THE FACILITY WISHES TO IDR THIS TAG1. The Residents cited in the survey were interviewed by the Social Services Director and no adverse effects were noted.2. All Residents were assessed and no other Residents were found to be affected.3. Staff were re-educated on Resident hygiene during meals. The Director of Nursing or designee will monitor 5 meals weekly. This observation will include all three meals and will continue indefinately.4. The Director of Nursing or desigee will report the findings of these audits to Quality Assurance monthly x 3 months and then at least quarterly.	04/08/2011

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F0241 SS=E	The Administrator provided a policy, titled, "Your Rights As A Nursing Home Resident" on 03/14/11 at 11:30 a.m. The policy indicated, "...You have the right to be treated with respect and dignity in recognition of your individuality and preferences...." 3.1-3(t) 3.1-3(p)(1)	F0241	THE FACILITY WISHES TO IDR THIS TAG1. The Residents cited in the survey were interviewed by the Social Services Director and no adverse effects were noted.2. All Residents were assessed and no other Residents were found to be affected.3. Staff were re-educated on Resident hygiene during meals. The Director of Nursing or designee will monitor 5 meals weekly. This observation will include all three meals and will continue indefinately.4. The Director of Nursing or desigee will report the findings of these audits to Quality Assurance monthly x 3 months and then at least quarterly.	04/08/2011

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F0252 SS=B	Based on observation, interview, and record review, the facility failed to ensure the resident's environment was maintained in a clean manner and dining furniture was maintained in orderly condition related to loose chair arms on the 8 of 13 stationary chairs in the main dining room and bugs in the 4 of 4 light fixtures in the therapy room. This deficient practice had the potential to affect 10 resident's who used stationary chairs in the main dining room and 11 residents currently receiving therapy services in the therapy room. (Main dining room and therapy room) Findings include: During the environmental tour on 3/15/11 at 9:40 a.m., with the Administrator, Maintenance Supervisor, and the Housekeeping Supervisor, the following was observed: A. There were 13 stationary chairs	F0252	1. No Residents were affected2. The chairs identified in the survey have been repaired and the light fixtures were cleaned. The Maintenance Director will check all the chairs in the dining room to ensure they are in repair 1x weekly for 4 weeks and then at least monthly as part of the Preventative Maintenance Program. The lights fixtures in the therapy room will be checked at least monthly as part of the Preventative Maintenance Program. 3. The Maintenance Director will report the findings to the Quality Assurance monthly x 3 months and then at least quarterly.	04/08/2011

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	located around tables in the main dining room. The arms on 8 of 13 chairs were loose and easily moved back and forth. During an interview with the Administrator at the time of the observation he indicated the arms of the chairs should not be loose at all. He indicated there had been no falls or injuries from the loosened arms on the chairs. He indicated the chairs are on the monthly maintenance logs to glue, screw, and repair any chairs that needed to be fixed. During an interview with the Maintenance Supervisor at the time of the observation he indicated he had checked all of the chairs 3 weeks earlier. He indicated he tightened the screws on some of the chairs. He indicated if the chairs could not be fixed when he looked at them during the monthly review, then the chair would be thrown away.			

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	During an interview with the Director of Nursing on 3/18/11 at 9:00 a.m., she indicated there were 10 residents who used the stationary chairs in the main dining room. Review of equipment record logs for the dining room chairs dated 1/11, 2/11, and 3/11 indicated the chairs had been repaired by tightening screws and gluing as needed. Review of the resident council minutes for January 24, 2011 indicated "...Department: Maintenance... Issue: Chairs: need new ones for dining room...." B. In the therapy room there were 4 of 4 fluorescent light fixtures with bugs located inside of the plastic cover. During an interview with the Maintenance Supervisor at the time			

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	of the observation he indicated he had not thought to check the fixtures in the therapy room. He indicated there should not have been any bugs in the fixtures. During an interview with the Director of Nursing on 3/18/11 at 9:40 a.m., she indicated there were 11 residents who receive therapy services in the therapy room. 3.1-19(f)(5)			

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F0272 SS=D	Based on observation, record review and interview, the facility failed to ensure accurate and comprehensive assessments were completed related to side rail use, incontinence status, and abdominal assessments. This deficient practice affected 2 of 14 residents reviewed for complete and accurate assessments in a total sample of 14 residents. (Resident # 23 and # 24) Findings include: 1. The clinical record for Resident # 23 was reviewed on 3/16/11 at 9:30 A.M. Diagnoses for the resident included, but were not limited to, advanced Alzheimer's disease. The resident was admitted to the facility on 1/2/11. A. Review of an activities of personal care sheet for 1/11 indicated the resident was incontinent of urine during the day shift on 1/3/11 and 1/4/11. Review of a "Urinary & Bowel Continence Evaluation" form, dated 1/5/11, indicated the resident was continent of urine at the time of admission and at the time of the assessment on 1/5/11.	F0272	1. Resident #23's bowel and bladder assessments were reviewed to determin accurance at the time of the survey. A side rail assessment was complted on 3/17/2011. Resident #24 had an abdominal assessment completed.2. All Residents were reviewed to ensure bowel and bladder assessments, side rail assessments and abdominal assessemtns were compelted and refleceted the current status of the Resident.3. The licensed nursing staff were re-educated on the completion of bowel and bladder assessments, side rail assessments, and abdominal assessments in relation to constipation. The Director of Nursing or designee will review the 24 hour report, the bowel records and all admissions 5x weekly to determine compliance. These audits will be completed indefinitely.4. The Director of Nursing of designee will report the findings of these audits to Quality Assurance x 3 months and then at least quarterly.	04/08/2011

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An admission minimum data set assessment (MDS), with an assessment reference date of 1/7/11, indicated the resident was occasionally incontinent of urine.

During an interview with Corporate Nurse Consultant # 1 on 3/17/11 at 2:40 P.M., she indicated that at the time of the resident's admission the facility did not know if she had a history of incontinence or not. She indicated the MDS assessment indicated the resident was occasionally incontinent. She indicated the assessment completed on 1/5/11 did not appear accurate.

B. During observation on 3/15/11 at 2:32 P.M., Resident # 23 was observed lying in bed with 1/2 side rails in the up position.

A current care plan for the resident, initially dated 1/2/11, indicated the resident was able to reposition herself in bed with the use of 1/2 side rails. An intervention related to this concern indicated staff were to complete a side rail assessment upon admission, with any significant change, and at least quarterly.

There was no documentation in the clinical record to indicate a side rail

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	assessment was completed for the resident at the time of the record review. During an interview with Corporate Nurse Consultant # 1 on 3/17/11 at 2:40 P.M., she indicated the side rail assessment was missed. She indicated that an assessment should have been completed. 2. The clinical record for Resident # 24 was reviewed on 3/17/11 at 9:15 A.M. Diagnoses for the resident included, but were not limited to, dementia with behaviors, schizophrenia, A current care plan for the resident, initially dated 2/21/11, indicated the resident was at risk for constipation related to decreased mobility. An intervention related to this concern indicated staff were to complete further evaluation and administer medications as ordered if the resident had no bowel movement for three days. Review of a the resident's bowel record for 2/11, indicated the resident did not have a bowel movement on 2/7/11, 2/8/11, or 2/9/11. The record indicated the resident had a large bowel movement on 2/10. There was no documentation in the			

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	clinical record to indicate the resident's bowel status was assessed during the three days that she did not have a bowel movement prior to 2/10/11. During an interview with Corporate Nurse Consultant # 2, on 3/17/11 at 3:50 P.M., indicated she could not say whether or not the staff should have completed an abdominal assessment because that is not what the facility policy indicated. 3.1-31(a)			

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F0282 SS=D	Based on record review and interview, the facility failed to ensure the resident's plan of care was followed related to the obtainment of a urine specimen with a straight catheter without an order from the physician and incorrect administration of Coumadin (an anti-coagulant medication). This deficient practice affected 2 of 14 residents reviewed for the following of the plan of care in a total sample of 14 residents. (Resident # 37 and # 45) Findings include: 1. The clinical record for Resident # 37 was reviewed on 3/17/11 at 11:35 A.M. Diagnoses for the resident included, but were not limited to, dementia, Alzheimer's, osteoporosis, osteoarthritis, hypertension, and transient ischemic attacks. A. A physician's order, dated 1/17/11, indicated the resident was to have a urinalysis and culture and sensitivity test completed to rule out a urinary tract infection. There was no documentation on the order to indicate staff were to obtain the specimen with a catheter. A nurse's note, dated 1/18/11 at 12:50 A.M., indicated, "Attempted straight cathing (without) success. Res (resident)	F0282	1. Resident #37 and Resident #45-The staff was instructed on the appropriate procedure for obtaining specimens. Social Service notes do not reflect that either Resident had any adverse effects. Resident #37-The MD was notified of the Coumadin administration and no adverse effects were noted.2. The physician orders were reviewed for the last 90 days to determine if any other Residents had orders for urinalysis and how these specimens were obtained. The medication administration records wre reviewed for all Residents receiving Coumadin. Any identified concerns were immediately communicated to the physician.3. The Director of Nursing or designee will review all physician orders 5x weekly for Urinalysis orders, Coumadin orders and/or PT/INR orders. These audits will continue indefinately. The medication administration records for all Residents receiving Coumadin will be reviewed daily for appropriate dosage. These audits will be daily until 100% compliance is acheived and then will be 5x weekly indefinately.4. The Director of Nursing or desigee will report the findings of these audits to Quality Assurance x 3 months and then at least quarterly.	04/08/2011

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	uncooperative holding legs tight together. Peri care given for clean catch/urine specimen dark yellow (with) white particles noted (and) slight odor...." There was no documentation in the clinical record to indicate staff had a physician's order to obtain the urine specimen using a urinary catheter. During an interview with Corporate Nurse Consultant # 2 on 3/18/11 at 11:45 A.M., she indicated education needed to be done with staff regarding the obtainment of urine specimens. B. A current care plan for the resident, initially dated 11/17/10, indicated the resident had the potential for hemorrhage due to the use of Coumadin. Interventions related to this concern indicated staff were to administer the resident's medications as ordered. Review of the 12/10 Medication Administration Record (MAR) indicated the resident had a physician's order for Coumadin 2 milligrams daily on Monday and Wednesday and Coumadin 4 milligrams daily on Tuesday, Thursday, Friday, Saturday, and Sunday. The record indicated the order started on 12/16/10.			

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	There was no documentation on the MAR to indicate the resident received a 2 milligram dose of Coumadin on 12/24/10 (Friday) and 12/25/10 (Saturday). The documentation on the MAR indicated the resident received a 4 milligram dose of Coumadin on 12/29/10 (Wednesday). A Prothrombin Time (PT) and International Normalized Ratio (INR) (a test used to measure bleeding times) result, dated 12/30/10, indicated the resident's PT level was 65.7 (normal range 10.1-11.6) and the INR was 5.9 (normal range 0.97-1.12). During an interview with Corporate Nurse Consultant # 2 on 3/18/11 at 11:45 A.M., she indicated she had no explanation for the incorrect administration of Coumadin. She indicated she looked for information to explain the error and did not find any additional information. 2. The clinical record for Resident # 45 was reviewed on 3/18/11 at 9:12 A.M. Diagnoses for the resident included, but were not limited to, senile dementia. A fax to the physician, dated 3/17/11, indicated, "...May we have order for UA (with) C + S (urinalysis with a culture and sensitivity) midstream clean catch (and) if unable to obtain midstream in (and) out cath?..." The fax was signed by the physician and he indicated the staff could complete the order as written. A nurse's note, dated 3/18/11 at 12:45 P.M.,			

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	indicated, "Attempted to cath resident unable to get. Resident went to BR (bathroom) and did urinate but spilled urine all over pants. Will try later..." There was no documentation in the clinical record to indicate staff attempted to obtain the urine specimen using a midstream clean catch technique prior to attempting to catheterize the resident. During an interview with Corporate Nurse Consultant # 2 on 3/18/11 at 11:55 A.M., she indicated she was not sure from the nurse's note documentation how the staff obtained the urine specimen. She indicated she understands the concern related to not following the plan of care. 3.1-35(g)(2)			
F0333 SS=D	Based on record review and interview, the facility failed to ensure resident's were free from significant medication errors related to the incorrect administration of Coumadin (an anti-coagulant medication). This deficient practice affected 1 of 14 residents reviewed for significant medication errors in a total sample of 14 residents. (Resident # 37) Findings include: A current care plan for the resident, initially dated 11/17/10, indicated the resident had the potential for hemorrhage due to the use of Coumadin. Interventions related to this concern	F0333	1. Resident #37-The MD was notified of the Coumadin administration and no adverse effects were noted.2. The medication administration records were reviewed for all Residents receiving Coumadin. Any identified concerns were immediately communicated to the physician.3. The medication administration records for all Residents receiving Coumadin will be reviewed daily for appropriate dosage. These audits will be daily until 100% compliance is acheived and then will be 5x weekly indefinitely.4. The Director of Nursing or designee will report the findings of these audits to Quality Assurance monthly x 3 months and then at least quarterly.	04/08/2011

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	indicated staff were to administer the resident's medications as ordered. Review of the 12/10 Medication Administration Record (MAR) indicated the resident had a physician's order for Coumadin 2 milligrams daily on Monday and Wednesday and Coumadin 4 milligrams daily on Tuesday, Thursday, Friday, Saturday, and Sunday. The record indicated the order started on 12/16/10. There was no documentation on the MAR to indicate the resident received a 2 milligram dose of Coumadin on 12/24/10 (Friday) and 12/25/10 (Saturday). The documentation on the MAR indicated the resident received a 4 milligram dose of Coumadin on 12/29/10 (Wednesday). A Prothrombin Time (PT) and International Normalized Ratio (INR) (a test used to measure bleeding times) result, dated 12/30/10, indicated the resident's PT level was 65.7 (normal range 10.1-11.6) and the INR was 5.9 (normal range 0.97-1.12). During an interview with Corporate Nurse Consultant # 2 on 3/18/11 at 11:45 A.M., she indicated she had no explanation for the incorrect administration of Coumadin. She indicated she looked for information to explain the error and did not find any additional information.			

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	3.1-48(c)(2)			
F0441 SS=E	Based on observation, interview, and record review, the facility failed to ensure staff followed infection control procedures related to handwashing, feeding techniques, and blood glucose machine disinfection. This deficient practice effected 4 residents in a supplemental sample of 6 reviewed for appropriate infection control measures. (Residents #30, #7, #42, #34, #4, and #26) This involved 4 staff members. (LPN #1, LPN #2, CNA #1, and CNA #3) Findings include: 1. During the lunch meal observation on 3/14/11 from 11:45 through 12:25 the following was observed: CNA #3 was observed feeding Resident #4 the lunch meal. The CNA got up from the stool she was sitting on to feed Resident #4 and went over to Resident #42. The CNA began rubbing the resident's back and arms in an effort to wake the resident up to eat. The CNA went back and sat down on the stool next to Resident #4 and began feeding the resident. The CNA repeated this sequence two times. The CNA was feeding Resident #4, stood up, picked up the stool	F0441	1. Residents #30, #7, #42, #34, #4, and #26 were monitored for any adverse effects and none were noted.2. After the facility was notified of the concerns, the staff was monitored to ensure no other Residents were affected and no other infection control breaks were observed.3. The staff was re-educated on infection control policies and procedures related to handwashing, feeding techniques and blood glucose machine disinfection. The Director of Nursing or designee will monitor 5 meals weekly which will include breakfast, lunch and dinner, and will continue indefinitely. The Director of Nursing or desigee will observe 5 medications/treatment administrations weekly to ensure proper handwashing, gloving techniques, and disinfection of the blood glucose machine.4. The Director of Nursing or desigee will report the findings of these audits to Quality Assurance monthly x 3 months and then at least quarterly.	04/08/2011

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	she was sitting on while feeding Resident #4 and carried it over to Resident #42 and sat next to the resident. She again began rubbing the resident's back and arms in an effort to wake the resident up to be fed by another staff member. She picked up the stool again and went back to Resident #4 and resumed feeding. At no time during the observation did the CNA attempt to sanitize her hands between touching the residents, touching furniture, and resuming feeding. During an interview with CNA #3 on 3/14/11 at 1:30 p.m., she indicated she should have sanitized her hands before resuming feeding of the residents. She indicated she "did not do that and I should have." 2. During an observation on 3/15/11 at 11:05 a.m., with LPN #1 the following was observed: The LPN got supplies ready to check Resident #30's blood glucose level. The LPN donned gloves, checked the resident's glucose level, and went back to the medication cart in the hallway outside the resident's room. The LPN laid the contaminated blood glucose machine on the medication cart. She changed her gloves, cleansed the blood glucose			

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	machine with a germicidal wipe, and laid the glucose machine on the medication cart in the same place, without a clean medium. During an interview with the LPN at the time of the observation she indicated she should have placed a clean medium between the medication cart and the newly sanitized blood glucose machine. She indicated she did not clean the glucose machine correctly. A policy and procedure titled "Blood Glucose Monitoring Procedure" dated 9/05, revised 1/10/10, and 3/11, provided by Corporate Consultant #1 on 3/18/11 at 10:00 a.m., identified as current, indicated "...Place medium (i.e., paper towel) between glucometer and any resting surface after glucometer is cleaned...." 3. During a medication administration observation with LPN # 2 on 3/15/11 at 4:20 p.m., the following was observed: The LPN assembled supplies to do the medication pass for Resident #34. The LPN donned gloves before entering the resident's room. The LPN entered Resident #34's room to administer the resident's medications. The LPN			

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	administered one Natural Balance Tears eyedrop in both eyes. The LPN removed his gloves. The LPN failed to wash his hands after removing his gloves. The LPN then administered a blood pressure medication in a spoon of applesauce and provided a drink of water to the resident by holding her pitcher of water. The LPN then combed the resident's hair, sat down next to the resident, and then held her hand. . The LPN waited 5 minutes, donned gloves, and then administered one Combigan eye drop in both eyes. After the second eye drop administration the LPN left the room with the gloves still in place went to the medication cart, put the eye drop containers in the medication cart, removed his gloves, and used hand sanitizer to clean his hands. At no time during the observation did the LPN wash his hands. During an interview with the LPN immediately following the observation he indicated he should have washed his hands after removing his gloves and should not have entered the hallway with the gloves in place. He indicated he knew better than to do that. During an interview with the Administrator on 3/15/11 at 4:45 p.m., he indicated the staff should be washing their			

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	hands after each resident contact and after removing gloves. A policy and procedure titled "Eye Drop Instillation Procedure" dated 9/05, identified as current, provided by the Administrator on 3/15/11 at 6:40 p.m., indicated "...wash hands...return medication to med. cart and record administration on medication record...."			

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F0441 SS=E	4. During the evening meal on 3/15/11 at 5:25 P.M., the following was observed: CNA (certified nursing aide) # 1 was feeding Resident # 26. CNA # 1 fed the resident's sandwich to him using his bare hands. During the observation, CNA # 1 touched the arm of the resident's chair and the hand of Resident # 7. CNA # 1 was not observed washing or sanitizing his hands during the feeding observation. A current facility policy, undated, provided by the Administrator on 3/15/11 at 6:40 P.M., titled "Handwashing Procedure" indicated, "...Specific times hands must be washed...2. Before and after direct resident contact 3. Before and after handling of food..." 3.1-18(l)	F0441	1. Residents #30, #7, #42, #34, #4, and #26 were monitored for any adverse effects and none were noted.2. After the facility was notified of the concerns, the staff was monitored to ensure no other Residents were affected and no other infection control breaks were observed.3. The staff was re-educated on infection control policies and procedures related to handwashing, feeding techniques and blood glucose machine disinfection. The Director of Nursing or designee will monitor 5 meals weekly which will include breakfast, lunch and dinner, and will continue indefinitely. The Director of Nursing or desigee will observe 5 medications/treatment administrations weekly to ensure proper handwashing, gloving techniques, and disinfection of the blood glucose machine.4. The Director of Nursing or desigee will report the findings of these audits to Quality Assurance monthly x 3 months and then at least quarterly.	04/08/2011

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F0469 SS=B	Based on observation, record review, and interview, the facility failed to ensure the activity room closets were free from mouse droppings. This deficient practice effected 22 of 54 residents who used the activity room on a daily basis. (3 of 4 activity room closets) Findings include: During the environmental tour with the Administrator and Maintenance Director, on 3/15/11 beginning at 10:00 A.M., the following was observed: There were 4 closets with bi-fold doors located on one wall in the activity room. There were 5 shelves in each closet. In 3 of the 4 closets mouse droppings were observed on the bottom shelves and on the items located on the bottom shelves. Items located on the bottom shelves with mouse droppings included 2 blankets, 2 plastic bins filled with non-toxic fabric paint, and 2 bread making machines. There was a mouse trap on the bottom shelf of the closet which contained the bread making machines. During an interview with the Administrator at the time of the observation he indicated he was not aware there was any mouse droppings located in	F0469	1. The area was immediately cleaned.2. The Pest Control Management Company was immediately called to the facility and no other areas were noted to be affected.3. The staff was educated on notifying the Administrator immediately if any signs of pests or rodents are identified. All staff will monitor through daily tasks and activity within the facility. The Pest Control Company will continue to service the facility monthly and as needed.4. The Administrator will make weekly rounds to all closets, common areas, etc. x 3 months and then at least quarterly. The Administrator will report the findings to the Quality Assurance x 3 months and then at least quarterly.	04/08/2011

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	the activity closets. He indicated a mouse had been reported to have been seen by a staff member in the activity room a month or so ago. He indicated the pest control company was notified and came to the facility that day and placed the trap. He indicated the facility receives pest control services monthly. He indicated the pest control company had no concerns identified related to mouse activity on the February or March inspections. He indicated he was only aware of the one mouse having been spotted by the staff. During an interview with the Administrator on 3/15/11 at 1:25 p.m., he indicated the pest control logs from 11/10 through 3/11 did not identify any concerns related to pest and rodent activity. He indicated he called the pest control company the day the mouse had been seen and they came in and placed the trap. He indicated the facility had a contract with the pest company that if any activity was identified by the pest company personnel the Administrator would be notified immediately. He indicated the company had never brought any concerns related to rodent activity to his attention. Review of the monthly pest control documentation from 11/10 through 3/11 indicated documentation was lacking			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	related to any mouse activity having been identified by the pest control company. Documentation each month indicated "...Public areas...pest harborage absent: Yes (checkmark)...infestation absent: Rodents Yes (Checkmark)...evidence of pest absent: Yes (checkmark)..." Each monthly pest control document was signed by the same pest inspector and the Administrator. Review of a letter signed by the Administrator of the facility and the pest control vendor dated August 11, 2010 indicated "...as part of the agreement to provide pest control services...we are requiring that you notify the Administrator...in the event you would find any issues that would deem sanitation a concern...." During an interview with the Activity Director on 3/18/11 at 9:20 a.m., she indicated there were 22 resident who utilized the activity room on a daily basis. She indicated the supplies on the bottom shelf of the closets were never used. She indicated she was not aware there was any mouse droppings on the bottom shelves of the closet until 3/15/11 when it was identified. During an interview with the Activity			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155743	A. BUILDING _____ B. WING _____	03/18/2011

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	Director on 3/18/11 at 10:45 a.m., she indicated no residents had access to the activity room closets. An undated policy and procedure titled "Pest Control Program" indicated "...it is the policy of the facility...that the facility maintain an effective pest control program so that the facility is free of pests and rodents. An 'effective pest control program' is defined as measures to eradicate and contain common household pests (e.g., roaches, ants, mosquitos, flies, mice, and rats). The facility shall maintain a contract with an exterminating service for routine inspection/treatment of the facility in an effort the facility remain free of pests and rodents...Should a staff member observe a concern with the presence and/or sighting of a pest/rodent (e.g., whether alive, carcass, or evidence of presence via droppings) the same shall be reported to the..Administrator for further action, as warranted...The contracted exterminator shall be notified as warranted in an effort to provide consultation and /or additional service in response to the identified concern." 3.1-19(f)(4)			

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